

PLEASE
DO NOT
STAPLE
IN THIS
AREA

°Private Provider
°Periodic Screening
°Vision and hearing

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																													
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>		MEDICAID (Medicaid #) <input checked="" type="checkbox"/>		CHAMPUS (Sponsor's SSN)		CHAMPVA (VA File #)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 900000000B															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Duck, Donald						3. PATIENT'S BIRTH DATE MM DD YY 05 03 1996			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street) 25 Quack Street						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)																				
CITY Raleigh				STATE NC		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY				STATE																
ZIP CODE 27600				TELEPHONE (Include Area Code) (919) 555-1212		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>			ZIP CODE				TELEPHONE (INCLUDE AREA CODE)																
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER																				
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME																				
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME																				
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																	
14. DATE OF CURRENT: <input checked="" type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP) MM DD YY						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY 11 15 2005						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17a. I.D. NUMBER OF REFERRING PHYSICIAN						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V20.2												22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																	
23. PRIOR AUTHORIZATION NUMBER																													
24. A DATE(S) OF SERVICE, FROM MM DD YY TO MM DD YY												B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OF SERVICE		H ICD-9-CM CODE		J ICD-9-CM CODE		K RESERVED FOR LOCAL USE	
1		11 14 02		11 14 02		11		99383		FP				80.33		1													
2		11 14 02		11 14 02		11		99173						0.00		1													
3		11 14 01		11 14 02		11		92551						0.00		1													
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER				SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>				28. TOTAL CHARGE \$ 80.33				29. AMOUNT PAID \$				30. BALANCE DUE \$ 80.33					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File												32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) Duck Pediatrics 175 Get Well Lane Raleigh, NC 27600																	
SIGNED _____ DATE 11/16/02												PIN# 8900000 GRP# 8901000																	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/98)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)